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ABSTRACT

The 1977 Denver coroner's report found that 45% of all suicide victims received psychotherapy at some time, and 21% were in treatment at the time of death. The literature on suicide places all responsibility upon the therapist. Four major sources of variance deserving consideration, however, are patient variables, therapist variables, treatment environment, and the wider social milieu. The crisis typically occurs within the first month or even day of treatment and is built around an escape fantasy which affects both the patient and the therapist. For the patient it serves as a suicidal motive, hides the patient's anxiety about terminating therapy, conceals patient's anger at therapist, restores patient's sense of self, and permits patient to construct a better world in fantasy. This fantasy serves the therapist by safely and successfully disposing of the patient, maintaining the therapist's own self-image, screening the shallowness of the patient's involvement in therapy, and denying the absence of a patient and therapist therapeutic alliance. A 10-year study of suicide treatment suggests focusing on the fantasy, continually re-evaluating the patient's death imagery and suicidal thinking, removing lethal means, offering constant mothering whenever the therapist is unavailable, freely offering regressive opportunities, offering particular concern at separation points, and following up serious suicide attempts. (Author/LS)

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An Approach to the Study of Patient Suicide During Psychotherapy

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An Approach to the Study of Patient Suicide During Psychotherapy

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The experienced therapist who has not encountered suicide among one of his patients is a rare individual. Indeed, most of us have experienced the psychic pain, guilt, and absence of closure that accompanies every completed patient suicide.

The suicide of a patient reverberates through the communities of patient and therapist alike. The damage inflicted upon survivors can be substantial. Each death comes to symbolize failure, lost opportunity and a diminution of the value of life in all who remain.

Consequent to the rapid growth of Comprehensive Community Mental Health Centers (CCMHC) and with the increasing popularity and diverse appeal of many different psychotherapies, suicides of patients in treatment are increasing rapidly. An inspection of treatment suicides recently uncovered in one major American city shed some light on the problem.

Coroners' reports on all suicides (N=143) in Denver, Colorado for 1977 showed that 45% of the 143 cases had received psychiatric care at some time in their lives, and 21% or 30 cases were in treatment at the time of death. Fourteen of these 30 individuals were under treatment at a CCMHC.

On a national level, MacKinnon and Farberow (1975) studied treatment deaths in the Veterans Administration (VA) hospital system. They reported an average of 66.6 suicides per year in VA neuropsychiatric hospitals for the years 1963-1972. For all VA hospitals, the average number of suicides per year for the period 1963-1972 was 134.

These findings indicate that treatment suicide is a significant obstacle to successful patient care. The obvious problem that a patient who has committed suicide can no longer be helped is compounded by the lack of routine or standardized approaches for managing the sequelae of the event. The Joint Commission on Hospital Accreditation does not outline procedures for coping with patient suicide. Some CCMHCs have functioning suicide study committees, and others schedule meetings following a suicide to discuss the case with both patients and staff. Still other centers have no organized approach to the problem at all. Generally, center personnel rarely reach out to the family members and other survivors of a patient suicide in an officially prescribed manner, although a great deal is done informally.

The literature on treatment suicide is fairly straightforward in placing responsibility for the suicides directly in the hands of the therapist. Bloom (1967) described six completed cases at the Lafayette Clinic where he was employed.

He found that:

> "The case reports demonstrate that each suicide was preceded by rejecting behavior by the therapist. This ..... is one of many contributing factors in suicide." (p. 918)

Bloom encountered formidable resistance in investigating these cases.

> "The therapists manifested defensive avoidance behavior with reference to this 'suicide study' ..... They never were the first to inform the author of the suicide and often either could not find the time for the interview or missed appointments. Some wanted to give the information in the form of a five minute briefing in the hallway. Recent psychotherapy notes were sparse, absent or lost. Promises to prepare a terminal summary were not kept. During the interview most therapists demonstrated denial, repression and isolation."

The author, however, did not try to establish a connection between his belief that the therapists of suicides rejected their patients, and the reluctance of these very same therapists to share with him their thoughts and feelings about the deceased patients. He concluded only that the completed suicide was causally related to therapist countertransference.

In a similar vein, Tabachnik (1961) also described patient suicides principally as a function of therapist countertransference. A typical crisis, he said, develops when the therapist, angered by the patient's unbearable demands, rejects him in a series of interactions with fatal consequences. Tabachnik wrote:

> "I believe that the attitude of the physician or other attendant may often be the result of a neurotic resolution of a conflict, and such resolution may take the form of rejection of the patient." (p. 65)

and again on the next page:

> "..... it is important for physicians to be aware of the possibility of neurotically solving their problems by rejecting their suicidal patients. This is often (takes the form of) a crisis which springs upon the therapist in a sudden and unexpected way." (p. 66)

Both Bloom and Tabachnik focus their discussions of treatment suicide on therapist error induced by unresolved countertransference feelings. This explanation appears, however, to be unnecessarily narrow. Could, for example, a case be made for some patient suicides occurring in the absence of therapist error? Or, could we possibly explain how some suicidal patients improve noticeably despite observed mistakes of their therapists? Indeed, no comparative data justifies

the arbitrary assignment of the cause of patient suicide to therapist behavior alone, nor is the theory supported by our current understanding of behavior as a function of a broadly based person-environment relationship.

In addition, years of study of the concept of lethality have made it apparent that some patients want to die much more than others, and such differences in intentionality (Psychiatric Annals, Nov. 1976) and lethality can be verified on the basis of demographics as well as personal characteristics and relationship patterns. Individual differences in lethality and intentionality must clearly be taken into account as significant variables in patient suicide.

But the complete study of patient suicide should extend beyond examination of patient and therapist variables to include both the immediate treatment environment and the wider social environment in which the patient functions.

Kobler and Stotland did this in part in their epic study, "The End of Hope", which traced the relationship between components of a mental hospital environment and patients' suicidal behavior in elaborate detail. Communication among staff members, consistency of leadership and openness of staff to expression of thoughts and feelings about suicide were some of the variables which they identified as mediating the treatment environment's impact on suicidal behavior. In

a series of brilliant examples Kobler and Stotland were able to demonstrate patients' considerable sensitivity and awareness of environmental considerations. They also showed that when the mixed messages endemic in a pro-suicidal environment were clarified, suicidal behavior among the patient group ended.

As a fourth consideration in studying treatment suicide, the influence of the wider social (non-psychiatric) environment can hardly be overlooked. The author personally observed a construction crew cynically shout encouragement to a suicidal man who had mounted a scaffolding many stories above the street and threatened to jump. In another striking instance of environmental reinforcement, the wife of a chronically suicidal elderly man laid out his only suit on their bed just prior to his suicide. Accounts of the recent suicides in Guyana by members of the People's Temple (see ref.) illustrate nicely how massive environmental pressure brought about the reluctant suicide of dozens, if not hundreds, of the group.

Thus, four major sources of variance that contribute to the understanding of any treatment suicide can be identified: patient variables, therapist variables, the treatment environment, and the wider social milieu. Certainly, in any given suicide, the relative importance of each factor will vary. This model is useful in that it goes beyond simply blaming the therapist for treatment suicide. Further research, however,

is required to develop it into a guide for suicide prevention programs. For instance, are the four components additive, or is a critical level of stimulation in only one sufficient to bring about a suicide? How can those conditions that retard suicidal behavior be identified and measured for each of the major sources of variance? What is the nature of the interactions over time between each of the major sources of variance? Elaboration of the model in these suggested directions can help focus efforts to prevent suicide in mental health facilities.

II.

The development of a fresh structural framework in which to view treatment suicide brings with it a new way of evaluating clinical features of the phenomenon. Typically, the events directly preceding a treatment suicide are distinctive: "A crisis which springs upon the therapist in a sudden and unexpected way" in Tabachnik's (1961) words. Experience has shown that the "crisis" is expressed in the form of an escape fantasy. Description of the common features of these fantasies (Selkin, 1976) and of their implications with respect to resistance and transference in the treatment setting is critical to understanding treatment suicide.

The crisis occurs typically within the first month of treatment and sometimes on the first day. It is built around

a fantasy which the patient has constructed about his future. The fantasy's content always reflects the patient's confused sense of self, and his ambivalence about the therapist, the treatment setting and his wider social environment. The patient feels that in the resolution of the fantasy lies the answer to the question of whether to live or die.

At age 21, John Jones' life could be viewed as a series of progressively more significant failures. He dropped out of college after completing less than a year's work, was unsuccessful in attempts to find and keep a job, and was discharged from the army for inability to adjust. He was married for about two years to a rising young bank executive. His wife became increasingly angry about providing for John's emotional and financial needs. Shortly after the couple moved to a midwestern city as a result of Mrs. Jones' job transfer, she found an apartment for John, paid the first month's rent, and filed for divorce.

John came to the mental health facility within a few days of separating from his wife. He complained of depression, low self-esteem, and suicidal thoughts. He needed to find work in order to survive. He was seen by a warm, friendly therapist, a giant of a man who recognized John's desperation, focused on his suicidal

thoughts and quickly developed a sense of rapport with him.

About two weeks later John came to see his therapist unannounced. He was filled with hope about his participation in a real estate project which held out promise of huge profits. After John had waited hours for an interview the therapist arrived and discussed the project with him. Unimpressed and surprised, the therapist indicated that the project was likely to fail as John had neither capital nor a real estate license.

John returned to his apartment and later that night shot himself in the head.

John's therapist provided a remarkably clear and detailed account of circumstances surrounding the suicide. The therapist was new at his trade, working as a therapist even though he was neither trained in psychotherapy nor had fulfilled the qualifications for any recognized professional status. The center where John was treated had been under substantial pressure to hire minority personnel in responsible positions, and as a member of an ethnic minority John's therapist was hired readily despite shortcomings in his qualifications. No supervision was provided for his work with John.

The account of John's suicide highlights the contribution

of treatment environment variables in that the center where he was treated provided unsupervised and untrained workers as therapists for highly suicidal patients.

Social environment variables were also influential in John's suicide. Despite his active involvement in psychotherapy and his known suicidal tendencies, he readily purchased the handgun with which he suicided from the proceeds of his first welfare check. Another treatment suicide case highlights the effects of the patient's past social environment on her interaction with the therapist.

> Jane, a 27-year old single woman, was admitted to hospital care in an agitated state. She was depressed, suicidal, and reported fantasies about committing suicide. Investigation revealed that she had graduated from a major university and was a trained computer operator. She had lived with a young man for two years, but following the break-up of that relationship had become transient and worked sporadically at menial jobs.
>
> Jane improved rapidly in the hospital and following three weeks of in-patient care was discharged to look for a job and continue therapy with the resident who cared for her in the hospital.
>
> A very strong transference developed simultaneously with the therapist's marriage and extended honeymoon.

On his return, Jane presented an elaborate plan to return East and resume the relationship with her boyfriend. After checking to see if Jane's father - who was to pay for the project - was in accord, the therapist agreed to the plan. On the next day, a Saturday, the therapist was called by police who apprehended her following a suicide attempt. The therapist explained the treatment plan to the police and urged them to release the patient. They complied, and that night Jane successfully completed suicide.

This sequence of events which simultaneously terminated treatment and the life of the patient is fairly typical of a significant number of treatment suicides in that the suicide was focally related to Jane's elaborate plan, or escape fantasy. Characteristically the crisis around which the fantasy develops occurs within the first month of treatment. Although details of the escape fantasy which accompany the suicide are frequently absent, and sometimes the entire fantasy is missing, in a few cases a complete account is available. An accompanying escape fantasy is the rationale the patient provides both to the therapist and to himself as the basis for his behavior.

The escape fantasy

1) serves as a source for the suicidal motive;

2) hides the patient's anxiety about terminating therapy;

3) conceals the patient's anger at therapist;

4) restores patient's sense of self;

5) allows patient to reconstruct a better world in fantasy than was available to him in reality.

In Jane's suicidal escape fantasy, she left treatment and reconstructed a previous environment which had been in at least some respects gratifying. She would no longer be lonely or broke. The pain of working with a therapist who had married someone else and in so doing had grossly rejected her affectional needs would be relieved.

Seen in retrospect, her fantasy had an additional clause which was not verbalized to her friends, police officers or therapist: If my fantasy does not work out, I will take my life. Thus, the outcome of the fantasy had been structured in a rigid all-or-nothing-at-all fashion. As the events of the weekend unwound, Jane became increasingly aware that the fantasy would not work, leaving suicide as the only possible alternative.

Jane's rage at the therapist for abandoning her to go on his honeymoon, for discharging her from the hospital and for refusing to readmit her was expressed in the fantasy by her intention to leave him. Her anxiety about terminating therapy was dealt with by recreating in her fantasy a past environment in which she was happy and did not need therapy. Her sense of self was preserved by creating, in the fantasy, a boyfriend

and a father who did want her, in contrast to the reality of the therapist who had rejected her.

The investigation of suicidal escape fantasies as presented to therapists in completed suicides always reveals that the therapist was seduced, as it were, by his own need to deny or endorse the propositions of the fantasy. In the case of Jane, the therapist was pressured by the constant need to reduce patient census on a busy, overcrowded ward. A student, he was reluctant to call his supervisor for help over a weekend. John Jones' therapist also had little time to work with John's crisis. Unable to use analytic concepts such as transference in his work because he had never been taught about them, he responded defensively to the patient's dependency and growing attachment. Therapist efforts to examine the defensive and transference features of the fantasy are, in retrospect, frequently found to have been half-hearted or nonexistent. In addition, significant elements in the treatment environment and wider social milieu are found to have been conducive to patient suicide.

A rather simple example of this point occurred some years ago in a Denver emergency room when a manic patient with a long history of previous hospitalizations was brought in for care. The patient expressed his need to be hospitalized at the VA hospital located across town because he knew the doctors there.

Though clearly in an agitated state, he told the E.R. doctor that he could easily drive across town. Simultaneously his brother and sister indicated that he was acutely psychotic and unable to drive by himself.

The E.R. doctor knew that admitting the patient to his hospital and then transferring to the VA would take several telephone calls and extensive paper work. He took the patient at his word and permitted him to drive to the VA hospital.

A few minutes later the patient smashed his vehicle into another car and killed a young mother. He was headed in the opposite direction from the VA hospital. Returned by the police to the emergency room, he looked at the doctor who had just released him and with a silly grin on his face said, "It was God's will."

In general, the escape fantasy serves the therapist's need in that it

a) disposes of the patient safely and successfully;

b) maintains the therapist's image of himself as a helping professional;

c) serves as a screen for the shallowness of the patient's involvement in treatment;

d) serves as a convenient denial for the absence of a therapeutic alliance between patient and therapist.

Therapeutic management of the escape fantasy is particularly

difficult when the patient is a drug or alcohol abuser. It is quite common for these patients to contract explicitly against suicide with therapists or treatment agencies, and then kill themselves almost incidentally after they have started drinking or using drugs again.

When the patient is not a substance abuser, therapeutic management of the escape fantasy requires focus on transference and defensive structure. Therapists need to adopt a restrictive and skeptical attitude toward the patient, making frequent use of hospitalization and other forms of environmental support.

Therapists should also be aware that escape fantasies which conclude in patient suicide place substantial strain on the involved therapist. In one instance a therapist suicided within 48 hours of the suicidal death of his young patient. Consultation and support need to be provided to the therapist in a nonthreatening context.

Some ten years study of completed treatment suicides in a mental health center have resulted in the development of several principles for managing and treating suicidal patients who are in the throes of a suicidal escape fantasy.

a) Interaction in psychotherapy needs to be focused on the fantasy's transference aspects and defensive meanings;

b) The therapist must continually re-evaluate the patient's death imagery and suicidal thinking by means of direct questions;

c) Lethal means of suicide such as handguns or dangerous medicine must be removed from the premises where the patient lives;

d) Therapist offers constant mothering such as telephone line or emergency service when he is not available;

e) Therapist freely offers regressive opportunities such as hospitalization;

f) Particular concern is given to separation points such as therapist termination;

g) Hospital or clinic facility provides for study and evaluation of completed cases and serious attempts.

Continuing research effort directed at specifying the suicide inhibiting features of treatment settings is seen as essential to the ongoing effort to reduce the incidence of treatment suicide.

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